Name: FMP/SSN last four: DOB:

Appointment Date: Contact Number:

12-18 YEAR VISIT

Do you have any specific concerns today? _____

_____

Any recent ER visits? ❑Yes ❑ No **When:** _____ **Reason:**_____

*****(Please complete information below: If filled out before, list only changes since the last visit.)*****

Chronic Medical Conditions (Circle all that apply)	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents)	Medicines (PLEASE INCLUDE DOSAGE)
Hay fever/Allergies **Asthma** **ADHD** **Overweight** **Chronic ear infections** **Other:**		**Hay fever/Allergies** **Asthma** **Other:**	**(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):** Do you ever forget to take your medications? ❑ Yes ❑ No

Check if anyone in the family has had:

□ High Blood Pressure □ Sudden Death □ Hypertrophic Cardiomyopathy □ Genetic or Metabolic Disease

□ High Cholesterol □ Long QT syndrome □ Obesity □ Mental Illness

□ Heart attack < 50 years □ Diabetes

Please list any known allergies you have (medication, food, latex) _____

Are you enrolled in the Exceptional Family Member Program (EFMP/Q-coded)? ❑ Yes ❑ No

Is your sponsor currently deployed? ❑ Yes ❑ No **Is this visit deployment related?** ❑ Yes ❑ No

Is either of the child's parents on PRP status? ❑Yes ❑ No

Are your immunizations up to date? ❑ Yes ❑ No ❑ Unsure

Who do you live with? _____

Do you attend: ❑ DOD school ❑ British School ❑ Home-schooled (Grade: ____) ❑ Aftercare **Concerns?** ❑ Yes ❑ No

Do you or anyone in your family smoke? ❑ Yes ❑ No

Do you feel safe at home? ❑ Yes ❑ No

What is your preferred method for learning: ❑ Verbal ❑ Written ❑ Visual ❑ Other: _____

Preferred language: ❑ English ❑ Other: _____

Are there cultural or religious considerations that affect your healthcare? ❑ Yes ❑ No _____

Check if you have a history of:

□ Trauma □ Fractures □ Fainting during exercise

□ Head Trauma □ Chest pain or discomfort □ Exercise intolerance

□ Concussion □ Palpitations □ Headaches

Diet History:

Are you a picky eater? ❑ Yes ❑ No **Does you usually eat large portions or multiple servings?** ❑ Yes ❑ No

# of servings of fruits & vegetables per day? ___ **# of times eating fast food per week?** ____

Do you usually eat dinner with your family? ❑ Yes ❑ No **Do you usually eat breakfast?** ❑ Yes ❑ No

Drink milk? ❑ Yes ❑ No How many ounces per day? _____ **What type of milk?** ❑ Whole ❑ 2% ❑ 1% ❑ Skim

Drink juice? ❑ Yes ❑ No How many ounces per day? _____ **Drink caffeinated beverages**? ❑ Yes ❑ No Number/week? ____

Exercise History:

Do you get at least one hour of physical activity at least 5 times per week? ❑ Yes ❑ No Type of activity: _____

How many hours of exposure do you have to TV/video games/computer time per day? _____

Do you have a TV or internet in your bedroom? ❑ Yes ❑ No

How many hours of sleep do you get on an average night? _____

Circle if you have any concerns about the following: Bowel movements / Sleep problems / Bedwetting / Vision / Hearing

Females only (if applicable): Last menstrual period _____ Any concerns about your periods? ❑ Yes ❑ No

Weight		Visual Acuity: R 20/____ L 20/ _____ Both 20/ _____
Height		Pain: ❑ Yes ❑ No Location of Pain _____
BMI/ %		
BP		Imm UTD per ASIMS: ❑ Yes ❑ No Technician Signature:_____

HPI:
H:
E:
A:
D:
S:
S:
S:

NE	Examination:	Normal	Abnormal
□	**General:**	□ Active/Alert/WN/WD/NAD/ not dysmorphic	□
□	**Head/Neck:**	□ NCAT, FROM, Neck supple, Nl thyroid, Nl lymph nodes	□
□	**Eyes:**	□ PERRL, RR X2, nl corneal reflex, EOMI, no strabismus	□
□	**R ear:**	□ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
□	**L ear:**	□ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
□	**Nose:**	□ Patent, No congestion/discharge	□ Congested
□	**Oropharynx:**	□ Pink, moist, no lesions □ Teeth: Nl, no signs of caries	□
□	**Lungs:**	□ CTAB, no retractions, nl WOB	□
□	**CV:**	□ RRR, no murmur, strong arterial pulses, cap refill < 2 sec	□
□	**Abd:**	□ Soft, NT, no HSM, no masses, nl BS	□
□	**Ext/Spine:**	□ NL, FROM, nontender, no edema, spine straight	□
□	**Skin:**	□ No rash/skin lesions	□
□	**Female:**	□ Nl breasts/Tanner ____ □ Nl ext genitalia/Tanner____	
□	**Male:**	□ Nl penis, Nl scrotum, Testes down, Tanner ____, No hernia	
□	**Neuro:**	□ Nl tone/strength/DTRs/balance/gait □ CN II-XII intact	□
□	**Musculoskeletal:**	□	□
□	**Other findings:**	□	□

LABS/X-RAYS:

ASSESSMENT: ❑ Well teen: normal growth & development for age
❑ Immunizations per clinic schedule
❑ Optometry Referral
❑ Sports Physical Form/Health Assessment form completed/returned

PLAN:

F/U: at next well visit at ___ years, sooner if parental or personal concerns
□ Patient and/or parent verbalizes understanding of treatment and plan □ Anticipatory guidance handout provided

PREVENTION: □ Dental care □ Safety □ Bike Helmet □ Seatbelts □ Tobacco avoidance □ Sun protection
□ Exercise □ Nutrition □ Media Time □ Relationships

Signature:_____
Date:
Stamp:

RECORDS MAINTAINED AT: ▶		
PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

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